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August 5, 2013

Ms. Karen Kimsey, Deputy Commissioner
Department of Medical Assistance Services
600 East Main Street
Richmond, Virginia 23219

Dear Ms. Kimsey:

On behalf of the Virginia Board for People with Disabilities (the Board), thank you for the opportunity to provide feedback on the pending Partnership Agreement between the Commonwealth of Virginia, the Centers for Medicare and Medicaid Services, and the health plan network for the Virginia Coordinated Care system. Per your guidance, this feedback is based on a review of the Massachusetts Partnership Agreement. It is our understanding that Virginia's agreement, currently in negotiation, remains confidential and that the Massachusetts agreement is not the same as the agreement that Virginia will ultimately sign. However, since the agreement will be similar, feedback on the strengths and weaknesses of the Massachusetts agreement has been sought.

Generally, the Massachusetts (MA) Partnership Agreement is very well written. It is clear and relatively devoid of jargon for an agreement of this length and comprehensiveness. The Board hopes that the Virginia (VA) agreement will be as reader friendly as the MA agreement. The Board is confining its comments to Section 1, Definitions, and Section 2.1-2.14, Contractor Responsibilities, specifically those that affect individuals with disabilities.

Section 1 - Definitions

- Independent Living and Long Term Services and Supports (IL/LTSS) and Long Term Services and Supports (LTSS) Coordinator. The MA agreement defines separately, IL/LTSS and LTSS Coordinator. We assume that the coordinator position in Virginia would be the case manager or service facilitator. The term independent is included in the definition of the

coordinator. However, under the separate definition of LTSS, the term independence is not included. The Virginia definitions should be consistent and include that critical term.

- Personal Care Assistant (PCA) and Personal Assistance Services (PAS). The definitions for PCA and PAS both reference activities of daily living and instrumental activities of daily living. These terms themselves should be defined.
- Independent Living Philosophy. If the term independent living philosophy is defined in the VA agreement, we recommend using a nationally recognized definition such as one used by that National Council on Independent Living.

Section 2.3 - Enrollment Activities

C (5). Initial Enrollee Contact and Orientation

- The specific references to ensuring materials are understandable to enrollees is positive. Translation and oral interpretation are specifically noted. We recommend that the VA agreement reference "accessible" communications which is more global, along with examples. DMAS may want to check with the Virginia Department for the Deaf and Hard of Hearing for appropriate language. Examples of alternative format materials should be provided. There should be a requirement that contractor's websites be Section 508 compliant under the Americans with Disabilities Act (ADA).

Section 2.5 - Care Delivery Model

B. Interdisciplinary Care Team (ICT)

- B(4)b. The Board supports having a requirement like MA for training of all members of the ICT in person centered planning, processes, cultural competence, accessibility and accommodations, independent living and recovery and wellness principles both pre- and in-service. We strongly recommend that there be a mandate that one or more individuals with disabilities serve as members of the training teams.
- B(5)a. The MA agreement refers to development of treatment goals (medical, functional, and social). The term "treatment" is appropriate for medical or behavioral health issues, but not for the delivery of long term services and supports that focus on increasing independence and achieving social goals. A person-centered not a medical model of service delivery is best practice for IL/LTSS. Therefore we recommend removal of the word "treatment" except when it applies to specific medical or behavioral health management/care.
- B(5)c. Although the enrollee is a member of the ICT, we recommend that the requirement to promote independent functioning and provision of services in the most appropriate, least restrictive environment specifically reference the choice and preferences of the enrollee. We also recommend that Virginia use the terminology of "most integrated setting," consistent with the ADA language, vs. "least restrictive environment" which is better known as educational terminology.

C. Care Coordination

Overall, this section could be improved in Virginia's agreement by detailing the importance of the enrollee's role in identifying the services needed, choosing service providers, making changes to their service plans, etc. The job description for the IL-LTSS coordinator does require training in person centered practices and other areas, but the actual description of the roles do not focus on enrollee participation or consumer direction. Working with the enrollee should be a concept included throughout the Partnership agreement as that would help confirm the Commonwealth's support of person centered practices and self direction with or without support.

- C(1). The MA agreement references care coordination through two individuals, the care coordinator or clinical care manager (CCM) and through an IL-LTSS Coordinator. However, other than both serving on the ICT, there is no clear description of how the Care Coordinator/CCM interacts with the IL-LTSS Coordinator. If the VA agreement anticipates having two care coordinators, we recommend that there be specific provisions regarding how they work together (with the enrollee) in between ICT meetings.
- C(4)e. The MA contract provides for a choice of two IL-LTSS coordinators but will allow for a choice of only one with prior approval. The Board supports enrollees having a choice in case managers and service facilitators and hopes that Virginia will provide maximum choice initially as well as in the circumstance of the individual's dissatisfaction with the person with whom they are working.
- C(4)e. The Board supports the provision in the MA agreement that prohibits service providers from also serving as IL-LTSS coordinators (or in VA's case, we assume this would be the case manager). The separation of case management from services provision has been a Board position for many years due to the potential for actual or perceived conflict of interest. The Board does not object to the exception that is included in the MA agreement as long as there are adequate quality assurance measures for monitoring approved exceptions.

D. Long-Term Services and Supports

Similarly to Section C, the requirements regarding Continuum of Care in the VA agreement should not only reference the obligation of the contractor to provide community alternatives to institutional care (as noted in the MA agreement) but should specifically require that the contractor work with the enrollee to discuss the enrollee's needs, preferences, and choices. This will ensure that the contractor provides meaningful options and choices to the enrollee.

F. Health Promotion and Wellness Activities

This section of the MA agreement references the need to provide interpreter services to enrollees who are not proficient in English. We recommend that the VA agreement use the more global

concepts of accessible communications and alternate format materials, with examples as appropriate.

Section 2.6 - Comprehensive Assessments and Individual Care Plan

A (4) and A(8). Comprehensive Assessment

- The MA agreement includes in its assessment "the ability of the individual to communicate concerns or symptoms, including whether physical symptoms are manifested through behavior." We believe that the requirements under Section A (8) relating to accessibility sufficiently address the communication accommodations. If this were to be included in the VA agreement, it would seem logical that A(8) appear prior to A(4). It is not until communication needs are identified and addressed that the ability of an individual to communicate concerns or symptoms can be effectively assessed.

Section 2.7 - Provider Network

A. General

- A (4)e. The MA agreement states that in establishing the provider network, the contract must consider the following: "The geographic location of providers and enrollees…and whether the location provides physical access for enrollees with disabilities." ADA accessibility of provider locations should be mandatory, with exceptions only granted in rural areas where there is a shortage of providers and where accessibility requirements are determined to constitute an unreasonable burden consistent with the ADA.
- A (16)-(21). The requirement for provider networks to be responsive to linguistic, cultural and other unique needs is an important one. Equally important is an assessment or evaluation of that responsiveness on a periodic basis. The Board recommends that the VA agreement ensure that within its quality assurance requirements such competencies are included.

D. Provider Education and Training.

- D(6). The Board supports the MA agreement provisions on provider training. These areas are all important. The Board suggests that the VA agreement include not only person centered planning processes, but person centered practices as well since this philosophy goes beyond just planning. The MA agreement addresses this in part by further specifying maximizing enrollee involvement in his/her own care. Some of these areas could be combined and written in a more focused area that also addresses self/consumer direction and informed decision making.

Section 2.8 - Network Management

A. General Requirements

- A(4)e. The Board recommends that the content of Provider Manuals refer to accessible communications and reasonable accommodations, not just interpreter services as denoted in the MA agreement.

H. Personal Assistance Service (PAS) Network

- H(3). The Board recommends that timely manner be defined in terms of completion of PAS evaluations, should that be a separate component of the VA agreement. While referenced in this specific provision (and perhaps others not included in this comment), the term "timely" should not be left open to interpretation.
- H(4). The MA agreement denotes that PCAs hired by enrollees will be paid if they meet certain requirements contained in MA regulations. One of the key components of consumer directed services in Virginia is the ability of the individual to choose the person they wish to serve as their provider and train those individuals, who could be family members, friends, neighbors, etc. As the Commonwealth develops its agreement, it will be important to maintain consumer choice and control in selection of PCAs as the heart of consumer direction with appropriate safeguards.

Section 2.9 - Enrollee Access to Services

A. General

- A(1)c The Board strongly supports the language regarding reasonable accommodations, accessibility, and compliance with the ADA and Section 504 of the Rehabilitation Act. We recommend that in the VA agreement, this section be moved toward the front of the agreement, rather being than so far back (page 85 of the MA agreement).
- A(1)c [2]A. The Board recommends that DMAS check with the Department for the Blind and Vision Impaired regarding the provision of large print materials to individuals with vision impairments. The MA agreement requires 16 pt. font. Members of the Virginia Board for People with Disabilities who have vision impairments have stated that an 18 pt font is preferable.
- H(1)-(4). The Board recommends that Virginia use the term most integrated setting vs. least restrictive setting in its provisions related to service authorizations or any other provisions.

Section 2.10 - Enrollee Services

A. Enrollee Service Representatives (ESRs)

- A(9). The Board recommends that in the VA agreement, training be required for customer service representatives in the use of the technologies described in this paragraph. All too often, technology is available but not utilized. With changing and advancing technology, it is

critical that service providers actually know how to use the accommodations they are required to provide.

Section 2.14 - Marketing, Outreach, and Enrollee Communication Standards

A. General Marketing, Outreach, and Enrollee Communication Requirements

- A(1)c. The Board strongly supports the requirement in the MA agreement that all educational, marketing and sales events must be held in physically accessible locations on public transportation lines.

B. Marketing, Outreach and Enrollee Communications Materials

The Board supports having a similar section to this in the VA agreement that ensures alternate format and understandable language materials, including prevalent foreign languages.

We appreciate this opportunity to provide feedback on the MA agreement that we hope will be helpful in finalizing Virginia's Partnership agreement. Please contact me if you have any questions or need additional information. I can be reached by phone at (804) 786-9369 or by e-mail at Heidi.Lawyer@vbpd.virginia.gov.

Sincerely,

Heidi L. Lawyer

Cc: The Honorable William Hazel, M.D., Secretary of Health and Human Resources
Keith Hare, Deputy Secretary of Health and Human Resources
Matt Cobb, Deputy Secretary of Health and Human Resources
John Kelly, Board Chair, VBPD
Linda Redmond, Ph.D., Policy, Evaluation, and Program Mgr., VBPD